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THE ROLE OF EXPOSURE THERAPY IN THE PSYCHOLOGICAL TREATMENT OF PTSD

Terence M. Keane, Ph.D.

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Exposure treatments within cognitive-behavior therapy emerged in response to the need for more intensive, direct, and effective interventions for crippling anxiety and stress disorders. Successful in the treatment of agoraphobia, panic disorder, social anxiety, specific phobias, and obsessive-compulsive disorder, these therapies have more recently been applied to the treatment of posttraumatic stress disorder (PTSD). The purpose of this article is to describe the fundamentals of exposure therapy and its many variants, describe how it is used in the treament of PTSD, and to offer guidelines for when to use this potentially very effective technique within a comprehensive approach to treating PTSD.

Behavioral and cognitive models for conceptualizing PTSD have already appeared in the literature (1-3). These models describe the premise from which one operates in using exposure treatments; this premise is critical to understand and appreciate before implementation of these treatments, but will not be reviewed here as it is beyond the scope of the article. Readers are referred to the primary sources to obtain the requisite background for using exposure treatments.

Definitions of Exposure Therapy

There are many behavioral techniques that are circumscribed by the term exposure therapy including: "in vivo" and imaginal systematic desensitization (4); "in vivo" and imaginal flooding (5); implosive therapy (6); and certain extinction-based procedures such as graduated extinction (7), covert extinction (8), and participant modeling (7). Other techniques could also be readily understood as an exposure treatment, but were derived from models other than learning theory or experimental psychology and will not be included in this discussion (e.g. hypnosis, paradoxical intention). Eye movement desensitization and reprocessing (EMDR; 9), an essentially atheoretical technique, contains components of exposure therapy and cognitive therapy; due to its atheoretical basis and the specific training required for implementation, it will also not be reviewed here.

Systematic desensitization typically involves the pairing of relaxation with either images of the traumatic event (imaginal desensitization) or stimuli reminiscent of the traumatic event ("in vivo" desensitization). Returning to the scene of a traumatic event and gradually approaching the cues that are most evocative of the emotions associated with the traumatic event while practicing cued relaxation responses (e.g., deep breathing, relaxing imagery) would constitute "in vivo" exposure to traumatic cues. Careful construction of the graduated hierarchy in concert with the client permits the therapist to monitor the extent to which the client is successfully coping with the anxiety inducing cues and to determine if the client is ready for the next step on the hierarchy.

A period of crisis drives many patients into therapy and this is clearly not the time to conduct any form of exposure treatment. Initial efforts are best directed at crisis resolution, stabilization, and modification of substance use.

Soliciting feedback from the client at each step of the hierarchy while simultaneously encouraging the use of the relaxation helps the therapist to determine whether a particular step on the hierarchy has been mastered and if the client is prepared for the next step. When using desensitization the emphasis is clearly on a graduated approach to the traumatic cues coupled with the use of a competing cognitive or behavioral relaxation strategy (i.e., imagery or deep muscle relaxation).

Imaginal desensitization involves the use of imagery and follows the same fundamental principles as those used in "in vivo" desensitization. The obvious distinction is that imaginal desensitization utilizes memories, images, or other cognitive representations of the traumatic event. In both

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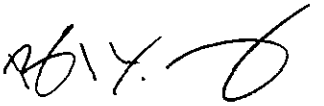
FROM THE EDITOR...

Certain PTSD treatments may be therapeutic to one individual but not another, and careful consideration of individual risk factors is necessary. Not all clients or patients, for example, are candidates for intense affective recall of their traumatic experience. Moreover, as **David Johnson** and **Hadar Lubin** point out in this issue of the *Clinical Quarterly*, there is not a universal cultural or treatment value placed on asking survivors to talk about the past when the past is associated with painful events. The multi-dimensional characteristics of PTSD require multi-level psychosocial and psychoeducational interventions. This issue takes a look at post-traumatic stress interventions from several contextual perspectives: **Terence Keane**, president-elect of the International Society for Traumatic Stress Studies (ISTSS), provides an overview of exposure therapy and discusses the importance of patient-treatment matching; **Karin Thompson, Michelle Hamilton,** and **Jeffrey West** provide a description of a symptom-driven group treatment for PTSD-related nightmares; **Mike Maxwell** describes the value of developing a PTSD treatment model for continuum of care; **David Johnson** and **Hadar Lubin** report their observations of PTSD treatment in Vietnam; **Karen Sitterle** and **John Tassey** describe interventions following a community disaster; **Matthew Friedman**, current President of ISTSS, discusses the need for continued development of an integrated national mental health disaster response; and **Marylene Cloitre**, the newly appointed editor of the Clinical Quarterly's ***Women and Trauma: A Clinical Forum,*** inaugurates a column devoted to the treatment of women. Dr. Cloitre specializes in the assessment and treatment of sexually victimized women and is an Assistant Professor of Psychology in the Department of Psychiatry at New York Hospital-Cornell University Medical College and Director of the Trauma Recovery Study at the Payne Whitney Clinic in New York.

Many allied health professionals, including myself, had the privilege of working with **Karen Sitterle** and **John Tassey** following the bombing of the federal building in Oklahoma City. Amidst the horror of violent senseless death, the intense anxiety of families waiting to hear about loved ones, and the frenzy of worldwide media coverage, Dr. Sitterle's and Dr. Tassey's leadership, sensitivity, and organizational skills helped structure the support needed for family members and emergency responders. Though John and Karen minimize their efforts, many, many people were helped and are indeed grateful for their work.

The winter issue of the *Clinical Quarterly* will review stress reactions of peacekeepers following international peacekeeping operations and the spring issue will address treating childhood sexual abuse in adults. In addition, we plan to add a regular column, ***Practitioner Network***, edited by **Julian Ford**, Deputy Executive Director for Education and Clinical Networking for the NC-PTSD. *Practitioner Network* will provide descriptions of innovative approaches to clinical and preventive services as well as reports on program development and evaluation being undertaken by specialized PTSD programs and practitioners.



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approaches the therapist constructs the hierarchy in conjunction with the client, and then moves to the next element of the hierarchy when and only when the client has mastered the previous element. There is input and feedback from the client throughout the process and this permits a client to experience control in the therapeutic process.

Flooding (5) can also be implemented either imaginally or "in vivo." It is typically defined as exposure to the traumatic cues to promote the experience of anxiety (or other aversive emotions) in the context of therapy. Clients approach the traumatic cues in the presence and safety of the therapeutic relationship, experience the emotions associated with the cues, experience the inevitable decline in affective experience (although this can sometimes take a considerable amount of time: 100 or more minutes), discuss alternative constructions of the event and its meaning, and repeat this sequence multiple times until the event or cues become increasingly less aversive.

Implosive therapy (6, 10) is an imaginal technique that promotes exposure to the original traumatic event using memory reactivation. When it is impossible to utilize 'in vivo" exposure, implosive therapy can effectively provide the medium for accessing traumatic memories. Implosive therapy is distinguished from imaginal flooding by virtue of its use of cognitive variables that are correlated with the development of PTSD (e.g., hopelessness, loss of control, etc.). These variables can be central to the development and maintenance of traumatic symptomatology and thus crucial to introduce in the exposure therapy to evoke the affective response and initiate emotional processing of the event.

While other exposure based techniques such as participant modeling and image habituation (11) have been examined in the treatment of PTSD, more precise details of technique implementation can be obtained from the original sources. Readers will notice the extensive overlap with the theoretical premises of the above techniques as well as procedural similarities. Most impressive in the single case applications of these approaches is the creativity of therapists in focusing upon the key symptoms of clients and developing a technique that promotes exposure in the most optimal way, thus contributing to the alleviation of symptom complaints in their clients. This flexibility comes from first, an appreciation of the theoretical mechanisms underlying the use of exposure treatments, and second, experience in conducting exposure therapies. Equipped with these two prerequisites, a competent therapist can readily incorporate exposure treatments into their range of options with traumatized clients and patients.

Literature Review on Exposure Therapy in PTSD

Solomon, Gerrity, and Muff (12) reviewed the psychological treatment outcome literature in PTSD finding essentially five projects that met their criteria of random assignment to condition, pre- and posttest evaluation, and the presence of a comparison group. They concluded that exposure therapies held the most initial promise among the treatments that had been examined empirically. A study by our group (13) indicated that exposure therapy was particularly effective for approximately two-thirds of the subjects in the trial resulting in systematic symptom reductions across a wide range of intrusive and arousal types of symptoms. That study did not find changes in the avoidant/numbing symptoms, a finding that may be a function of the assessment instruments we used or the limitations of the technique. Further studies with superior dependent variables such as the Clinician Administered PTSD Scale (14-15) will help determine the extent to which these preliminary findings are robust.

Subsequent studies were designed to replicate and extend these findings. Cooper and Clum (16) and Boudewyns and Hyer (17) also found that those who received exposure therapy embedded in a more comprehensive treatment program experienced greater reductions in PTSD symptoms than those who did not receive the exposure therapy. These studies were also conducted with combat veterans.

Moreover, Foa, Rothbaum, Riggs, & Murdoch (18) demonstrated that among women with rape-related PTSD, those subjects who received exposure based treatment showed continued improvement following post-treatment assessments. These subjects' psychological condition was superior to that of the subjects receiving stress inoculation treatment at a three month follow-up.

Other studies contribute to the conclusion that the use of an exposure component in the treatment of PTSD has beneficial effects above and beyond what is offered in traditional treatment approaches. In the only controlled study conducted outside the United States, Brom, Kleber, and Defares (19) demonstrated that systematic desensitization was as effective as other approaches in the treatment of PTSD secondary to multiple types of traumatic events. To date, issues of culture, ethnicity, and race have received little attention in the PTSD treatment literature, largely due to the relatively small sample sizes employed in existing studies.

Clearly, the numerous single-subject design studies (e.g., 20-28), coupled with the more methodologically strong randomized studies reviewed above, indicate that exposure treatment is effective in the alleviation of traumatic symptomatology. The questions for the clinician, then, are with which patients is exposure therapy most effective, for what kinds of symptoms, and at what point in therapy should exposure treatment occur? Unfortunately there are few data to guide the clinician in making these decisions. Consequently, the remainder of this article will attempt to provide the reader with guidelines developed through clinical experience.

Phase Oriented Treatment of PTSD

PTSD patients' symptom patterns are phasic in nature (29-30) with periods characterized by intrusive or reliving experiences alternating with periods of avoidance and numbing symptoms. Sometimes these periods are overlapping and at times they are sequential, lasting variable lengths of time. When patients are experiencing an exacerbation of their condition it is usually in response to current stressors or to exposure to cues reminiscent of the traumatic event. These periods of exacerbation often involve destabilization in the lives of patients and considerable psychological and social disorganization. There is frequently an accompanying problem of substance abuse.

A period of crisis drives many patients into therapy and this is clearly not the time to conduct any form of exposure treatment. Initial efforts are best directed at crisis resolution, stabilization, and modification of substance use. Until there is some degree of stability in the life of the patient it is unwise to begin any form of intensive therapy. This is the *Emotional and Behavioral Stabilization Phase* of our multiphasic approach to PTSD treatment (31).

The second phase of treatment is centered upon teaching the patients about their disorder, the effects of chronic PTSD, implications for their interpersonal relations, responses to ordinary stressors, and the

course of the disorder. This *Trauma Education Phase* is marked by an emphasis on providing a fundamental understanding of the ramifications for people who are exposed to life-threatening, traumatic events and who develop PTSD.

Phase three emphasizes the teaching of specific skills to assist individuals to manage their anxiety, stress, and response to interpersonal stressors. Relaxation training, interpersonal skills training, anger management training, and problem solving treatments comprise the primary skills taught to patients. Collectively these skills are described as the *Stress Management Phase*. These skills, once mastered, are important for use outside the therapy setting, but will also be critical in instilling in the patient a sense of efficacy about managing stressors. This will be invaluable as patients enter the next phase of treatment wherein the focus changes from skill acquisition to emotional processing of the traumatic event and its sequelae. As work in therapy shifts to the traumatic event patients can utilize their newly developed stress management skills to help them manage the stress that will be evoked.

Trauma Focus Phase of treatment occurs when the patient has mastered the necessary skills so that they feel more prepared for intensive, direct intervention regarding their traumatic event. It is in this phase where exposure therapies are employed. This treatment component can be systematic desensitization, flooding, implosive therapy, or any of the variants described above. These options are seen as preferable for the processing of a traumatic event, compared with insight or talk therapies, largely because they incorporate behavioral, physiological, and cognitive cues, providing more complete access to the complex of factors thought to be involved in processing human emotion (32-34).

Foa and Kozak's (35) convincing extrapolation from the bioinformational theory of Lang (32) posits that these exposure-based procedures optimize the patient's capacity to access all dimensions of the traumatic memory network, provide a corrective therapeutic experience, permit a reduction in emotional valence through extinction processes, which then promotes a cascade of adaptive cognitive processes to occur, such as challenging of irrational heliefs, crippling attitudes, and dysfunctional values. If there are multiple traumatic events, each traumatic memory can be treated sequentially and with input from the patient as to the preferred order that each will be addressed.

As therapy proceeds, patients need to he equipped for the inevitable recurrence of symptomatology. Stressors that are related or even unrelated to the traumatic events in question can trigger a return of traumatic symptomatology. In the *Relapse Prevention Phase* of treatment the patient is instructed how to best manage and master the return of symptoms. Efforts to mobilize social support systems and to promote the use of stress management skills when stressors occur will extend the effects of the more intensive phases of therapy.

Since many patients in public sector treatment facilities evidence chronic PTSD, it is valuable to incorporate an additional component of treatment. *Follow-up and Maintenance Phase* of treatment for PTSD includes the development of the expectation that the therapist is available as a consultant as the need may arise. For some patients the use of self-help groups may provide the necessary structure for promoting adaptive change and the maintenance of treatment gains. Booster sessions can be scheduled to provide specific points of access to support by the therapist and treatment sessions can be systematically phased-out over an extended time.

If there are multiple traumatic events, each traumatic memory can be treated sequentially and with imput from the patient as to the preferred order that each will be addressed.

This six phase approach to treating PTSD provides a heuristic framework for interventions geared to the adult PTSD patient (Table 1). While it is recognized that the treatment of PTSD cannot he easily compartmentalized and that at times patients require extended periods within a single phase before advancing to the next phase, this method does provide the clinician with both long-and short-term strategies and specific goals for managing PTSD patients.

Table 1. Six -Phase oriented treatment of PTSD

1.	Emotional and Behavioral Stabilization phase
2.	Trauma Education phase
3.	Stress Management phase
4.	Trauma Focus phase
5.	Relapse Prevention phase
6.	Follow-up and Maintenance phase

Treatment Caveats

Our phase oriented approach to treating PTSD assumes that patients are ready and prepared to proceed from one phase to another. Clinical judgment in concert with patient input are the determinants of whether an individual is, in fact, ready to proceed to the next phase. Some patients will require longer amounts of time in one stage or another depending upon their clinical condition. For other patients, it may be necessary to return to earlier phases if their clinical status demands additional time to master their objectives of that phase. Clearly the phases that we have proposed are both fluid and dynamic in nature in that the clinician can judge the extent to which an individual needs additional treatment of a certain type. In practice, the clinician works in conjunction with the patient to determine the next steps in the treatment program. Goals and objectives are routinely discussed and modified on the basis of the progress experienced.

Clinicians who are trained in exposure methods for treating other forms of psychopathology will find the need to address several issues when applying these skills to PTSD. First, it is valuable to have a consultant or a supervisor who has experience with this particular patient population. This advisor can provide insights into the process of recovery in traumatized patients. Second, if a patient's life is disrupted either through family crises or other forms of social instability, this is not the time to initiate intensive exposure therapy. Focus should remain on the first phase of therapy with perhaps an extension into the third phase.

Third, if a patient is involved in active substance abuse, the focus should be on containment and stabilization of the patient's condition with the more intensive trauma focus phase being implemented when a period of sobriety has been attained. Recommended lengths of time for sobriety vary, particularly when PTSD is involved, largely due to the fact that many patients abuse substances to ease their traumatic symptomatology (36). For these patients it is preferable to begin the more intensive and direct exposure therapy earlier in the sobriety (e.g. 8-12 weeks). The sooner their therapist can provide relief from the PTSD symptoms, the more likely it is that the patient will remain sober.

There are clearly many variables to be weighed by the clinician in these situations and no peremptory rules can be developed. In the balance is the therapeutic need to have a stable and sober patient prior to intensive treatment versus some patients' inability to achieve stability and sobriety without relief from their traumatic symptoms. If the clinician waits too long to effectively intervene, the patient may become increasingly hopeless and leave therapy. If the clinician intervenes too early, the patient may not be able to tolerate the stress associated with the processing of their traumatic histories and resort to alcohol abuse or other maladaptive patterns (37).

Fourth, the presence of multiple traumatic events is also a consideration in the use of exposure approaches to treatment. Previous studies from our group indicated that patients with memories of four to six traumatic events can be successfully treated using exposure. Each memory is considered an independent entity and hierarchies are developed accordingly. However, for some people, particularly those who have experienced war, the number of traumatic events to which they have been exposed can conceivably be dozens. While there are no existing studies on this topic, we have chosen to use approaches that emphasize containment in such instances (e.g. supportive counseling, education, stress management, skills training, etc.).

Efforts to mobilize social support systems and to promote the use of stress management skills when stressors occur will extend the effects of the more intensive phases of therapy.

A fifth caveat in the use of exposure treatments is the presence of complicating medical and psychiatric comorbidity. Patients with cardiovascular disease including angina, a history of myocardial infarction, and severe hypertension might well be ruled out as candidates for any evocative or intensive therapy. In addition, patients with poor cognitive functioning, psychotic thought processes, or with impulse control problems (i.e., actively suicidal or homicidal) would not be good candidates until their conditions were stabilized. As with all therapies, patient noncompliance with therapist instruction would also preclude the use of exposure therapy. A good therapeutic alliance is an important consideration. For further discussion on this topic, Litz, Blake, Gerardi, and Keane (38) have proposed additional guidelines for the use of exposure therapy in the treatment of PTSD.

Summary. Exposure therapies are empirically documented, effective treatments for PTSD. Efficacy studies with war veterans, rape victims, and survivors of a broad array of traumatic events demonstrate that this form of treatment is a valuable addition to a therapist's clinical skills. When utilized with a comprehensive treatment program that addresses the psychological, social, and physiological elements of the disorder, exposure therapies offer innovative methods for addressing the symptoms of PTSD and for alleviating the residual emotions, distress, and physiological reactions to specific traumatic events. Future research is necessary to further document the effectiveness of treatments for PTSD and data are needed to substantiate the efficacy of the phase-oriented treatment program described in this article.

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UNCOVERING PTSD IN THE REPUBLIC OF VIETNAM

David Read Johnson, Ph.D. and Hadar Lubin, M.D.

David Read Johnson, Ph.D.

Hadar Lubin, M.D.

In October, 1994, we led a delegation of 27 clinicians and scholars interested in post-traumatic stress disorder and the creative arts therapies on a mission to Vietnam.[1] We met with physicians, psychiatrists, government officials, and Vietnamese combat veterans in Hanoi, Hue, Da Nang, and Ho Chi Minh City. We toured several medical/surgical and psychiatric hospitals, a rehabilitation center for disabled veterans, facilities of two medical schools, and met with American diplomats in the American POW/MIA office. Our movements were not constrained or controlled by the Vietnamese government, and

A view of the countryside outside of Hanoi.

we were able to examine numerous patients and speak with many people in the streets. In this article, we will briefly summarize what we learned about health care, psychiatric treatment, and concepts of post-traumatic stress disorder in Vietnam.

General Conditions of the Country

Vietnam remains a profoundly third world, impoverished country. The population is 70 million, 80% of whom live in rural areas. The yearly income per capita is $132. The war with Cambodia and China during the 1980s strained an already ravaged country and economy. Most buildings are the unpainted remains of French structures from the 1930s, with families living in one room open to the street, where they eat and work. There are old unused street lights, no stop lights, and only a few telephones in Hanoi, a city of 500,000.

In 1986 economic reforms similar to those in Russia were instituted, allowing limited private enterprise. Over the next few years, the country improved its situation, so that by 1989, Vietnam exported rice for the first time, and is now ranked third in the world behind Thailand and the US in rice exports. While they have enough food to feed their people, 30% remain malnourished due to poor distribution systems. In 1989, they opened relations with the West, and have made normalizing diplomatic relations a high national priority. The transfer of Hong Kong to China in 1997 continues to motivate them to seek alliances with the US and other powers. The longstanding hatred of the Chinese is still palpable (so intense they adopted the Latin alphabet in 1920 to prevent the Chinese from being able to read their language!).

General Health Care System

The health care system is hierarchically organized into seven regions, 40 provinces, 537 districts, and 10,000 communal areas. At the commune level the health care team consists of four people: an assistant doctor, a nurse, a traditional medicine doctor, and a "hygienist," similar in function to a social worker. There is one hospital per district, one or two provincial hospitals, and one or two national hospitals linked with the major medical schools.

Most medical care is free (though unavailable), including abortions on demand. The health care budget per capita per year is 66 US cents. There are a total of 400 hospitals and 6000 medical beds in the country.

The psychiatrists at the center as well as the patients clearly view sequelae of the war as a physical condition similar to shell shock. They termed the patients' condition as "serious brain problems, due to the noise from the war."

The major priorities healthwise include sanitization of the water supply, immunization of children, family planning, and prevention of malaria, typhoid fever, dysentery, and other diseases. The immunization program has achieved 85% success. 1700 cases of HIV have been identified, mostly in the South. Other health problems include care for 4.4 million handicapped people and 300,000 orphaned children in the country. Needless to say, psychiatry is not a priority.

We visited the provincial hospital in Hanoi, Viet Duc, and were profoundly shocked at the terrible conditions of care: crowded open air

wards with no glass in the windows, wooden beds without sheets or mattresses, unsanitary conditions (operating rooms open to the air and to visitors), and ill-equipped (one 30 year old X-ray machine, one EKG machine, and severe shortages of medicines, bandages, and books). Families huddled around patients (including children) recovering from major surgeries without the aid of pain medications, bandages, or vital monitoring.

Medical Education

There are seven medical schools in the country, training 300 students a year. The training is three years, followed by a three year internsbip. Students must pass certifying exams similar to our Boards. Classes are taught in English, Russian, and French. Until recently, many doctors were trained in Russia. There are 7,000 doctors and 48,000 assistant doctors in the country. There are only 360 psychiatrists and a handful of psychologists. Psychiatrists are just now beginning to open private offices in Saigon. Traditional medicine is still a part of medical training - all doctors receive two months of classes in acupuncture and herbal treatment — though these skills are still transmitted from father to son within certain families. In rural communities these doctors provide much of the primary care, while in the cities interest in traditional methods is waning. Doctors receive from $20 - $50 per month salary, far less than the salary of our tour guide, or anyone in direct contact with Western companies.

Two women in their room at the Hoa Khanh psychiatric hospital in Da Nang.

The University of Medicine in Ho Chi Minh City is divided into medicine, dentistry, and pharmacology schools, with a total of 500 faculty and 50 professors. There is a separate School of Nursing, which involves three years of training beyond high school, and separate schools for assistant doctors. The condition of the medical school is startling: they have almost no equipment (the Vice Dean of the Medical School asked us if we could send them some microscopes), pharmaceuticals, and medical textbooks (other than outdated French or Russian ones from twenty years ago).

Treatment of Veterans

Three and a half million Vietnamese served during the "American War," including Army of the Republic of Vietnam (ARVNs). During the war, 440,000 North Vietnamese and 220,000 ARVNs were known to be killed, and additionally a staggering 300,000 are missing, for a total of nearly a million dead. Hundreds of thousands of people are handicapped as a result of the war, or are suffering the effects of dioxin. Birth defects continue at a high rate in areas that were heavily defoliated. Veterans are treated in separate hospitals and clinics controlled by the Ministry of Defense. Currently there are about 15,000 war veterans permanently housed in treatment centers, and many more being cared for in brief inpatient treatment centers and outpatient clinics.

There are 80,000 Amerasian children (now young adults) most who have emigrated to the US. Some remain in the one "school" near Saigon, though officials reluctantly acknowledged that many are unemployed and homeless, or have turned to drug addiction or prostitution.

Women

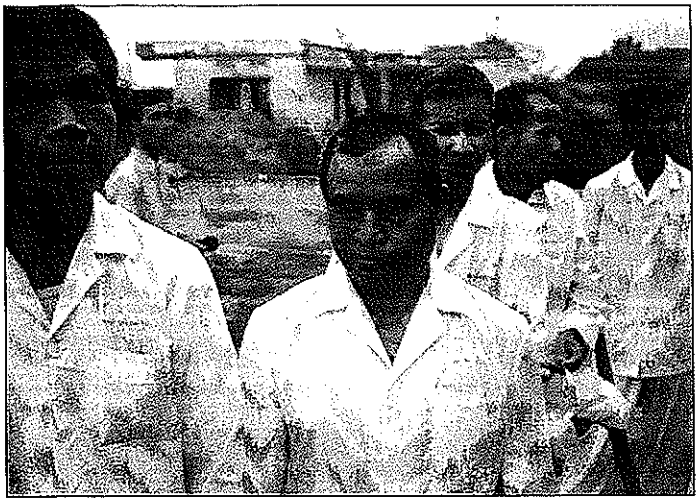
Many women served in combat-related roles during the war, however, the culture gives preference to the "war mother" as the container of the grief and loss associated with war. These mothers are highly honored and acknowledged. Each "war mother" who lost a child was given the equivalent of $4 as a pension from the government. In contrast, the young women who participated in the war were often unable to marry, and in their thirties found themselves unwanted due to the strongly held beliefs that they were too old to bear children. Many of these women subsequently suffer from depression and loneliness and are common among hospital patients. Rape is universally denied as a significant problem (as is homosexuality and domestic violence), and viewed solely as a crime, requiring only gynecological treatment.

Psychiatric Treatment

Psychiatric care remains largely custodial and palliative. While there is greater awareness of modern trends in psychiatry in the medical school hospitals in Saigon, in general the psychiatric facilities we visited were deplorable. One of the only general psychiatric hospitals in the country near Da Nang, Hoa Khanh, had been transformed from a children's hospital built by the American Army to a psychiatric facility in 1976. The hospital has 150 inpatient beds, a 50 day length of stay, and serves approximately 4000 outpatients over a year. The doctors there estimate that 12% of the patients (men and women) have war related traumas. We viewed small rooms filled with beds without mattresses. Patients were heavily sedated on neuroleptics. Many were restrained in leathers, and a seclusion area (locked rooms with bars) was indistinguishable from a prison. The only treatments available include listening to music, watching movies, or physical therapy (massage). Psychotropic medications mentioned by the physicians include amitriptyline, Wellbutrin, and Valium. The doctors were aware of the diagnosis of PTSD, but had no treatment for it. When patients had dissociative episodes, flashbacks, or violent outbursts, they would be held down by 5-6 aides, and then restrained in their bed if necessary. We witnessed two such incidents while we were there: in one case a forty year old woman with PTSD had a flashback when she entered the room to be interviewed and saw the delegation. She fell to the floor with epileptoid movements, screaming out in Vietnamese, "Don't beat me! I'll do what you say!" She had been a POW of the ARVNs, and had been severely beaten, tortured with electric current, and had soap put in her mouth while being hung upside down from a ceiling. Her husband, with whom she still lives, had been an ARVN. The second incident was with a young psychotic patient who required physical restraint and a

forcible return to seclusion. In both cases, the staff appeared remarkably calm and treated the patients with care, talking softly to them and holding them down. No sedatives were administered.

Ho Chi Minh City, with a population of over a million, has one 100 bed acute care psychiatric facility, a 200 bed hospital for chronic patients, one day hospital, one outpatient clinic, and one mobile team that visits the homebound. They are significantly more informed about Western psychiatry than their counterparts in the North: they use the *DSM-III-R*, having just received the *DSM-IV*. Their treatments, however,



Veterans at the Center for the Care of War Invalids outside Hanoi.

were similar to those we had seen in the North, including physical therapy, relaxation, and diversional activities. Living conditions for patients were bare rooms filled wall to wall with beds with no amenities. We were able to sit in on a session of their new group therapy program. We witnessed a doctor leading six patients in a group discussion about their problems. He seemed knowledgeable about how to redirect the patients to speak to each other and develop the group interaction, though he had not been trained in any particular group therapy method.

Treatment of PTSD

War veterans are classified by percent of disability and are treated in separate medical facilities under the Ministry of Defense. We learned that war veterans were housed in special clinics and hospitals on the outskirts of Hanoi, and our request to visit one was accepted. The Center for the Care of War Invalids covers about one acre of land with a dozen small buildings. The hospital takes care of 30-50 inpatients at a time for relatively brief stays of 20 days. They follow 500-600 patients in the community, 5% whom are women, providing what would be the equivalent of visiting nurse services. They seem to have a home-based health care orientation that recognized the need to provide support to the family of the veteran. The hospitalized patients receive food, rest, massage, reassurance, and medications, most commonly Ativan or amitriptyline, and then sent home. They are clearly honored as soldiers who fought for their country, and are provided marginally better living conditions than the civilian population.

The psychiatrists at the center as well as the patients clearly view sequelae of the war as a physical condition similar to shell shock. They termed the patients' conditions as "serious brain problems, due to the noise from the war." Patients told us how their "brain" was affected, pointing to their heads, telling us they put bandages around their heads when they feel the "pressure" from their disorder. One veteran said, "toxic substances like Agent Orange have made my heart beat fast." The focus on physical aspects of stress also includes the use of hydrotherapy and Russian-style psychiatric treatments such as ultraviolet light exposure and radio-wave irradiation of the joints, consistent with the notions of PTSD as a somatic stress condition.

We were able to interview several of the patients through a translator and soon discovered the presence of all three symptom clusters of PTSD. The veterans reported intrusive imagery, flashbacks, avoidance, anxiety, sleep disturbance, startle, as well as drug and alcohol use, depression, and survivor guilt. Emotional numbing was less strongly endorsed. When we asked one veteran if he is visited by dead buddies, the translator/doctor refused to translate the question because he felt it was absurd. When we insisted, the veteran burst into tears and replied, "yes they come every day." The surprise on the doctor's face told us much about his lack of knowledge about the psychological dimensions of the disorder.

When we asked one veteran if he is visited by dead buddies, the translator/doctor refused to translate the question because he felt it was absurd. When we insisted, the veteran burst into tears and replied, "yes, they come every day."

The physicians in general minimized the occurrence of war-related PTSD and reiterated the message of the larger culture that "we do not ask about the past," and "we look to the future - we understand that the past is filled with terrible things." Both patients and doctors uniformly told us that there is no point to dwell on the past but to look to the future with forgiveness and hope. Despite the supportive aspects of this approach, misdiagnosis was evident in many cases we examined. For example, in the facility in Da Nang, we interviewed a woman who was hospitalized for depression. She initially told us that her problems had nothing to do with the war, but upon inquiry we found that she had a major sleep disturbance due to nightmares about her father who was tortured and killed in the war. The doctors were completely unaware of this element of her condition.

Differences between the North and South

Significant differences in culture, orientation, and relationships seem to exist between the North and South. The North is substantially poorer, more rural, traditional, suppressed, and patriotic. In contrast, the years of capitalism remain an influence in the South, despite the overlay of communist control since the war. More significantly, the South experienced most of the actual physical destruction of the war, and the conflict within families caused by the civil war. Many South Vietnamese told us how their families had been split into ARVN and Viet Cong factions. In addition, thousands of ARVNs had to abandon their

families when they fled the country, were killed in the purge at the end of the war, or were put in re-education camps, creating ongoing disruption of family units. We were told that all the ARVNS were out of the camps by 1992 (17 years after the end of the war!), hardly a reassuring statistic. It is not surprising that we found more interpersonal tension among people we met in the South, and evasiveness in response to our questions regarding the war.

Culture and PTSD

Throughout our trip, we were impressed with the power of the broad cultural message to frame and contain potential distress in the populace. In Vietnam, not only revisionist propaganda, but also deeply held Buddhist beliefs and centuries of struggle as a small country, inform the people to move on and focus on survival. It is hard for Americans to fathom the extent of destruction caused by this war - perhaps only comparable to our own Civil War. There are graves everywhere, along the road, in the rice paddies, in numerous cemeterics that rival Arlington. Because the war took place on their land, the distinction between soldier and civilian in terms of trauma is not significant. The need to survive, economically as well as politically, given the proximity of their enemy China, propels everyone toward a convergent national goal and serves to suppress expressions of anger or pain. Our delegation members were highly skeptical when the leaders of the Vietnam Veterans Organization in Saigon proudly announced that they made no distinctions between NVA, VC, and ARVNs in their organization; that all had suffered and all could be members. Such levels of forgiveness are truly outside of our imagining. The openness and positive spirit we met everywhere were deeply disturbing to us, and we questioned it.

When we visited the History museum in Hanoi, one diagram was particularly instructive: a map of the world in 1328, showing the Empire of Genghis Khan including India, Europe, China, and all of Southeast Asia except for Vietnam. Three invasions over sixty years by the most ruthless warrior in history led to failure. A Vietnamese professor told us: "We have a long history of being invaded and governed by giants, though in the end we defeat them and they leave. Then, being such a small country, we must go back to these giants and apologize for our victory....now we must do this with America."

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[1]The Delegation was sponsored by the People to People Ambassador Program, created by Dwight Eisenhower in 1956 to further intercultural exchange. The members of the delegation included Lawrence Ashley, Mary Baures, Lois Carey, Nina Corwin, Marija Dixon, Brenda Doherty, Paul Frazer, Mildred Gustafson, Ron Hays, Robert Holmes, Mario Mercado, Margaret Mercado, Nancy Odell, Royal Randolph, Bonnie Riggenbach, William Root, Emily Rosenberg, Vernon Sackman, Niki Sepsas, Nancy Slater, Suzanne Sutherland, Richard Sword, John Uschuk, Candice Weigle-Spier, and Larry Winters.

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NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.
Executive Director, NC-PTSD

Towards A National Mental Health Disaster Response

Since 1989, VA professionals have provided acute and longer term mental health interventions following Hurricanes Hugo, Iniki, and Andrew, following the Loma Prieta and Northridge Earthquakes, and following the riots in South Central Los Angeles, the Oakland Hills fires, the Midwestern floods, the Oklahoma City bombing and other natural or man-made disasters. The VA's nationwide network of hospital, clinic and Vet Center-based PTSD clinicians provides a pool of sophisticated clinicians who are tactically situated to offer timely and effective post-disaster mental health interventions anywhere in the United States. In addition, the National Center has provided education and training, program evaluation, clinical consultation, research, and leadership in each disaster. The key, and as yet unmet, challenge has been to create or identify a consistent mechanism through which such expertise can be made available during national and local emergencies.

Shortly after the bombing of the federal building in Oklahoma City, I began to receive phone calls from a number of VA PTSD clinicians who wanted to participate in mental health interventions for survivors or for families and friends of victims who had been killed in the explosion. Each of these callers had an expectation that their offer to interrupt their lives and leave their families in order to provide post-disaster clinical expertise in a distant city would be gratefully accepted and that they would be quickly dispatched to Oklahoma as part of a federal mental health disaster response. Most of them believed this because of VA's unquestionable leadership in this field and because of VA's participation in the National Disaster Medical System (NDMS) as its fourth mission behind clinical care, research and education. At the present time, VA resources and capabilities have not been integrated with an overall national mental health disaster response. Indeed, there is no clear structure under which a VA component of a national mental health disaster response can be consistently implemented and coordinated with the activities of other disaster response agencies.

I am addressing this column to the many VA PTSD clinicians who were willing to go to Oklahoma City and who look forward to a time when they will be called to participate in a national mental health disaster response in which VA personnel can be rapidly mobilized to provide needed services for people and communities in crisis after a natural or man-made disaster. As detailed in the last issue of the *Clinical Quarterly*, the National Center did play an important consultative role to assess immediate and long-term recovery needs of the community (Fred Gusman and Bruce Young) and also provided training for on-site mental health professionals and substance abuse counselors several weeks later (Francis Abueg, Fred Gusman, and Bruce Young). What is needed, from my perspective, is coordinated advance planning to assure that VA's PTSD and mental health crisis response experts are deployed in a timely manner with clear role assignments in coordination with other key federal, state, and local agencies. To advance this agenda, the National Center has been working in several ways to help develop a national mental health disaster response plan that incorporates new knowledge and new institutional capabilities regarding post-traumatic interventions.

Recognizing the need for a better coordinated and more consistent mental health disaster response at the federal level, the National Center participated in the convening of an Interdepartmental Task Group on Disaster Crisis Counseling (ITGDCC) two years ago. Chaired by Larry Lehmann, MD from VA (Mental Health and Behavioral Sciences Service), this group has met on an ongoing basis to provide a forum for collaboration among representatives of VA's Emergency Management and Preparedness Organization (EMPO), the Department of Defense (DOD), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), The American Red Cross, VA Readjustment Counseling Service, the National Center, and other government officials. The task is to make recommendations regarding a national mental health disaster plan. Progress has been slow due to institutional inertia, the complexity of the assignment and because of different interpretations of pertinent legislation delineating authority and responsibility.

From my perspective, the ITGDCC has a great opportunity to:

1. incorporate VA post-traumatic expertise and capabilities within a coordinated mental health disaster plan that integrates federal with local resources;

2. recommend consistent minimum professional standards and credentials for mental health crisis responders and post-traumatic stress clinicians who wish to be eligible to provide such services;

3. recommend a consistent strategy for identifying those disaster survivors who need mental health intervention;

4. identify state-of-the-art assessment techniques to monitor outcomes from such interventions;

5. recommend a program evaluation strategy to determine the cost-effectiveness of such an approach.

I believe these goals are achievable and that VA can make a substantial contribution towards the design, implementation and evaluation of a national mental health disaster plan.

WOMEN AND TRAUMA: A CLINICAL FORUM

Marylene Cloitre, Ph.D.

This column is devoted to the exploration of the role of trauma in women's lives among both the veteran and nonveteran populations. Its goal is to provide clinicians and researchers with a place to exchange information and ideas via brief articles, literature, book reviews and announcements. If you wish to have material included in this column, please contact Marylene Cloitre at Payne Whitney Clinic, Box 147, New York Hospital- Cornell Medical Center, 525 East 68th Street, New York NY 10021 or at email address: mcloitre@mail.med.cornell.edu

Treatment of Trauma among Women

This Quarterly's column provides information about effective treatments available for women who have experienced adult sexual assault or child sexual abuse. Treatment approaches for rape and child sexual abuse (CSA) trauma have developed relatively independently. The treatment of rape trauma has been organized around the PTSD construct, highlighting anxiety symptomatology. In contrast, treatments for childhood sexual abuse trauma have emerged from developmental models which have focused on the difficulties that CSA victims have in self-integration and interpersonal functioning, expressed in symptoms such as dissociation and affective dysregulation. This review will highlight some of the major work in both areas and point to the efforts being made to integrate information across the different treatment models.

Psychotherapy for Rape-related PTSD

Although there has been some controversy on the issue, PTSD has been placed under the umbrella of the anxiety disorders. A benefit of this categorization is that the study of PTSD has rapidly advanced by building on cognitive-behavioral theories deriving from the study of other anxiety problems (e.g., conditioning, information processing) and by utilizing techniques that had already been demonstrated to manage or reduce anxiety symptoms such as fear, intrusive thoughts, hyperarousal and avoidance.

Three treatments have shown to be effective in the resolution of rape-related PTSD. Stress Inoculation Training (SIT), adapted by Veronen and Kilpatrick (1), begins with a psychoeducational component concerning both learning theory and rape-specific issues of self-blame and responsibility. This component is followed by a skills training component where the client learns to manage the cognitive, physiological and behavioral aspects of anxiety symptoms. SIT does not involve a formal exposure component. However, recently, Foa and colleagues (2) have successful used a prolonged exposure (PE) treatment. The client is asked to relive the rape trauma as vividly as possible, by repeatedly describing it out loud and in the present tense during sessions and by listening to taped recordings of the narrative at home.

In a well-controlled study, Foa and colleagues (2) found that both SIT and PE were effective treatments. However, SIT produced greater reduction in PTSD symptoms immediately after treatment, while PE produced superior outcome at three and one-half months follow-up. Foa and colleagues suggest that the relapse associated with SIT may be the result of reductions in practicing the skills techniques, a critical component in maintaining gains. In contrast PE creates immediate increases in distress and arousal but is expected to lead to permanent changes in the rape memory, leading to ongoing and sustained improvement in functioning.

As attention to the treatment of rape and other crime victims has intensified, clinicians have noted that strong emotions other than fear are associated with PTSD. Resick and Schnicke (3), for example, note that crime victims often experience a range of other strong feelings such as shame, guilt, anger, disgust, and depression. Resick has developed Cognitive Processing Therapy (CPT) which is based on an information processing model which views PTSD and other trauma symptoms as deriving from an inability to resolve conflicts between the traumatic event and prior beliefs about the self or others. The goal of the treatment is to challenge maladaptive beliefs that have emerged as a result of the rape and to reorganize their meanings and associated feelings into the belief system in an adaptive way. The treatment has been found effective in both individual and group formats.

Psychotherapy for Childhood Sexual Abuse

The PTSD construct has been less central in the development of treatment for women with child sexual abuse (CSA) trauma. Rather, a developmental perspective has been taken which suggests that child abuse results in disruptions in the childhood tasks of a) self-organization, leading to symptoms such as dissociation and affect dysregulation, and b) self-other relatedness, leading to difficulties such as maintaining stable relationships. Much of the information we have about child abuse victims derives from studies of individuals with Borderline Personality Disorder (BPD). However, it remains to be seen whether this diagnosis accurately captures the nature and severity of the sequelae of abuse victims. Many women with CSA histories do not have symptoms severe or extensive enough to warrant the BPD diagnosis. Additionally many other clinicians working with this population have been impressed by the strong dissociative characteristics of this group which are not well represented in the BPD diagnosis.

Treatments for this population have emphasized a group approach with strong interpersonal elements. Treatment studies have utilized with success the process orientation established by Yalom (4). For example, Alexander and colleagues (5) found that when compared to a wait-list group of CSA patients, a 10-week process group and a more structured 10-week interpersonal transaction (IT) group showed significant symptom reductions. The members of the process group discussed their incest histories, their goals for the group, and a range of other group-selected topics. In addition, substantial work revolved around the group members' actual interactions with each other as a means of understanding their problematic behaviors, changing these behaviors within the group and generalizing these changes to interactions outside of the group. The IT treatment was more structured and, along with whole group interactions, included the pairing of group members into dyads in which nonjudgmental sharing of information was the goal.

Towards an integration of treatment approaches

The treatment models associated with adult and childhood sexual assault are distinct, but recent empirical investigation indicate the value of "cross-over work." For example, the rates of PTSD among adults with childhood abuse were assessed in the DSM-IV field trials and were found to be quite high. Foa has reported success in using prolonged exposure in a small sample of incest victims. Conversely, Susan Roth has suggested that the cognitive-behavioral treatments which have proved so successful for rape victims have strong interpersonal elements in them, such as communicating trust in the patients' ability to solve their problems. Lastly, the notion of countertransference reactions, a key concept in the interpersonal tradition, has been transported to the context of the treatment of PTSD as exhibited in a recent book, *Countertransference in the Treatment of PTSD* edited by Wilson and Lindy (6). Considering that the systematic study of the nature and treatment of sexual assault was initiated only 15 to 20 years ago, it seems worthwhile to search broadly across different disciplines and perspectives for meaningful organizing principles and to test a range of potentially effective treatment techniques.

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GROUP TREATMENT FOR NIGHTMARES IN VETERANS WITH COMBAT-RELATED PTSD

Karin E. Thompson, Ph.D., Michelle Hamilton, Ph.D. and Jeffrey A. West, Ph.D.

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Michelle Hamilton, Ph.D.

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The reexperiencing of traumatic events in the form of repetitive dreams with accompanying feelings of anxiety, terror or sadness is one of the primary dysfunctional manifestations of post-traumatic stress disorder (PTSD; 1-3). Nightmares and related symptoms are severely problematic for large numbers of PTSD-diagnosed veterans traumatized during war (4-5) who have been shown to recall and report more repetitive dreams than do individuals without PTSD symptoms (1,6) and to evidence greater maladjustment in proportion to the intensity and prominence of their dream disturbances (7-8). Such veterans commonly report that recurrent dreams cause them to relive actual wartime trauma scenes and reexperience intense emotional states, such as rage, fear, or grief, that were invoked during the original events (3,6).

Typical acute sequelae following PTSD-related combat nightmares include agitation, sudden awakening, severe dysphoria, and inability to return to sleep, creating both immediate and protracted problems related to insomnia, extended arousal, and lingering negative emotional states. These symptoms compound distress in a population prone to suffer severe disruption as a function of sleep deprivation (2). Moreover, posttraumatic combat nightmares appear to sustain and solidify threatening themes, thus exacerbating complexity and chronicity of PTSD symptomatology over time (3), and survivors may continue to experience persistent nightmares with little or no relief for decades following the trauma (5,9). Clinicians' ability to alleviate these problems has been limited, frequently relying on prophylaxis with benzodiazepines or other medications to suppress intrusive symptoms and lessen sleep disturbance (10), or dream analysis to enhance insight and coping. Unfortunately, many patients continue to reexperience traumatic stress in nightmares despite such efforts and develop additional problems related to perceptions of loss of control, decreased self-efficacy, and hopelessness surrounding their inability to sleep without intrusion.

Daily monitoring of inpatients over the past year at the New Orleans VA Medical Center Evaluation/Brief Treatment Unit (EBTPU), a six-week, 10 bed PTSD treatment program, has documented that an average of six nightmares per week have occurred at baseline across all admitted male combat veterans. A significant majority of patients (90%) have reported experiencing post-trauma nightmares while admitted to the EBTPU, with a lifetime prevalence approaching 100% among veterans who report they have ever dreamed. As in prior studies conducted on inpatient PTSD programs (e.g.,1), recurrent nightmares have occurred with high frequency despite the fact that most patients have been maintained on medications. Thus, there has been a need for expanded methods to help EBTPU veterans actively reduce, alter, or better cope with nightmares and their consequences, ideally involving patients directly and proactively in a manner complementary to other skill-enhancing aspects of their PTSD treatment.

Review of the nightmare treatment literature reveals that a majority of investigations in this area have examined patients diagnosed with dream anxiety disorder but not necessarily PTSD, and that treatment effectiveness has been demonstrated with cognitive-behavioral techniques (11). Relaxation training and systematic desensitization are among the most studied interventions that have been shown to reduce non-trauma nightmares (12-13). These procedures were examined because nightmares are associated with daytime anxiety and stress and because relaxation effects can persist into sleeping hours (13). Another promising treatment approach, imagery rehearsal, is an exposure-based intervention in which the subject rehearses a changed version of the recurrent nightmare using cognitive imagery (14). Studies of dream anxiety disorder patients have shown that nightmares were completely eliminated in cases where favorable or "masterful" endings were imagined (15-16) and significantly reduced with neutral endings (16). Imagery rehearsal instructions in a group setting also have been shown to reduce nightmares significantly following a single session (17).

...posttraumatic combat nightmares appear to sustain and solidify threatening themes, thus exacerbating complexity and chronicity of PTSD symptomatology over time.

The imagery rehearsal intervention currently offered to EBTPU PTSD inpatients with trauma-related nightmares has been tailored for this

application and combined with specialized relaxation training to enhance effectiveness in this highly anxious treatment population. Upon admission, each patient is asked to initiate monitoring of numerous sleep and dream related variables using a "Daily Sleep Activities Log" (see Table 1). Group treatment starts during Week Two of the program, with sixty-minute sessions that are held once each week for three consecutive weeks.

Table 1. Daily Sleep Activities Log (abbreviated version)

1. What is the total number of hours slept during the night?
2. Did you feel depressed when you woke up? *(rate 1-5)
3. Did you feel rested when you woke up? *(rate 1-5)
4. A nightmare is a dream producing feelings of intense fear or other negative emotions. Did you have any negative nightmares? (enter 0 for none, or 1, 2, etc.)
5. How disturbing were they? *(rate 1-5)
6. Did you have any dreams that were not nightmares? (enter 0 for none, or 1,2, etc.)
7. Did you dream your target dream?
8. Was there any change in the content of your target dream?
9. How disturbing was your target dream? *(rate 1-5)
10. Did dreams occur before or after 1 a.m., or both?

*Rating Scale:

1	2	3	4	5
Not at all	Mildly	Moderately	Very	Extremely

Session One begins with a brief overview of the impact of nightmares on sleep and daytime functioning among PTSD veterans. The facilitator emphasizes that nightmares come from within the individual, who has the potential to exert control over dreaming with the use of imagery rehearsal. The two primary tasks of Session One are to identify a target dream and assign the nightly practice of relaxation (see Steps 1-3, Table 2). Patients are asked to choose a recent recurring nightmare for intervention. During the group, they recount details of the dream, including accompanying and consequential emotions, and are asked to specify whether their nightmare is a reliving or a symbolic dream. Patients tend to experience strong affect as they recount traumatic incidents during this session. Expression of emotion is accepted and encouraged, and veterans are urged to support one another. However, each patient is prompted to focus on a target dream rather than the incident upon which it is based; often the dream will differ from actual historic events in detail. Each veteran is instructed, as a homework assignment, to describe the dream on the "Target Nightmare Experience Form - Original Version" (see Table 3) in as much detail as possible and to bring this to the next group.

Patients are also instructed in Session One to choose the relaxation technique that has proven most effective for them (as learned in a separate stress management group) and to practice this technique each night before going to sleep and during any episodes of awakening throughout the night. The importance of utilizing relaxation to reduce bedtime anxiety associated with the fear of nightmares and to facilitate a return to sleep following premature awakening is emphasized. Patients are instructed to use available audiotapes providing progressive muscle relaxation, autogenic, and imagery training. Session One concludes with an in-group relaxation practice using imagery and progressive muscle relaxation, intended to reduce the likelihood that patients will leave the group in an uncomfortable or emotionally aroused state, and to promote a sense of self-efficacy. Patients receive the "Instructions for Nightmare Group" handout (Table 2) at the end of the session and are instructed to follow Steps 1 through 3.

Table 2. Patient Handout: Instructions for Nightmare Group

Step 1. Practice relaxation techniques each night before you go to bed.

Step 2. Choose a recurring nightmare you would like to work with in this group. This will be your target nightmare.

Step 3. Write down your target nightmare with as many details as possible. Include sensory descriptions (sights, smells, sounds, tastes, etc.). Also include any thoughts and feelings you have during the dream.

Step 4. Choose a change for the nightmare.

Step 5. Write down the full nightmare with the change.

Step 6. REHEARSAL + RELAXATIONS: Practice rehearsal of the changed nightmare by visualizing the entire dream with the change each night before practicing relaxation techniques.

Step 7. Visualize the entire dream with the change, and practice relaxation, as often as possible during the day.

Table 3. Patient Handout: Target Nightmare Experience Form - Original Version

In the space provided below, please describe the distressing dream in as many details as possible. Include sensory descriptions (sights, smells, sounds, tastes, etc.). Please note the feelings, images, and thoughts associated with this dream, being as specific as possible. Note when the dream begins and when it ends.

In my dream,

The beginning of Session Two is devoted to inquiring about whether group members were able to practice and achieve relaxation and assisting them in finding ways to enhance their practice, if necessary. Patients individually then read aloud to the group their prepared written descriptions of target dreams. Next, each veteran individually or with group assistance selects an alteration for their nightmare. Changes may occur at the beginning, middle, or end of the dream and alterations may be positive, negative, or neutral, according to individual patient preference. The first rehearsal of the altered dream occurs in this session as each veteran recounts verbally the changed version of the dream and is assigned as homework the task of providing a written description of the full dream with the alteration, including as many details and emotions as possible, on the "Target Nightmare Experience Form - Changed Version" (see Table 4). Veterans are also instructed to rehearse the changed nightmare, using imagery, each night before practicing relaxation techniques at bedtime and as often as possible during the daytime.

...Patients who experience significant guilt may be less amenable to treatment...An exploration of this resistance often revealed underlying guilt and the belief that the nightmare was a way to preserve and honor the memory of a dead buddy or important event, or to punish the guilty survivor.

Table 4. Patient Handout: Target Nightmare Experience Form - Changed Version

In the space provided below, please describe the changed dream in as many details as possible. Include sensory descriptions (sights, smells, sounds, tastes, etc.). Please note the feelings, images, and thoughts associated with this dream, being as specific as possible. Note when the dream begins and when it ends.

In my changed dream,

Session Three is used to follow-up on the intervention and provide feedback and assistance for any problems that may have arisen. All patients are asked whether they rehearsed the changed dream and, if so, how often. They are also assessed regarding their relaxation practice. Barriers to rehearsal and relaxation are explored, with the veteran and other group members engaging in problem-solving, if necessary. Patients are instructed to continue their individual intervention efforts and self-monitoring on a daily basis throughout the remainder of their inpatient stay, with suggestions for continued use of rehearsal and relaxation techniques following discharge.

The intervention is thought to be effective in part because it occurs within the context of an inpatient treatment program for PTSD. Inpatient status not only allows for consistent monitoring of nightmares and sleep patterns, but also provides an integrated program of treatment to address issues critical to the reduction of nightmares specifically and sleep disturbance more generally, including sleep hygiene education, relaxation training, and medication education. Equally important is the opportunity for patients to work on the "real-life" traumatic incidents underlying their nightmares through enrollment in trauma processing and grief groups, where trauma-related issues including guilt, shame, horror, and grief can be fully addressed. Participation in a nightmare treatment group without benefit of these supporting treatment resources would be less likely to address the comprehensive needs of this population and might seem simplistic and superficial to veterans.

Compliance has been enhanced additionally by (a) allowing more in-session practice; (b) encouraging individuals to remind one another to practice interventions before bed; and (c) instituting a daily monitoring check early in the morning, with opportunity to discuss sleep-related issues from the night before.

Our experiences and insights gained in group nightmare treatment have led to the following observations and practical recommendations which may be useful for mental health professionals planning to implement such an intervention:

1. Expect and address compliance problems as a regular treatment issue. As with other combat-focused interventions that trigger unpleasant memories, veterans sometimes exhibited a tendency to avoid both the individual and group components of the nightmare treatment. This was addressed in group with the rationale that discomfort inherent in exposure to traumatic memories could be preferable to the continued

experience of nightmares at baseline frequency. Compliance has been enhanced additionally by (a) allowing more in-session practice; (b) encouraging individuals to remind one another to practice interventions before bed; and (c) instituting a daily monitoring check early in the morning, with opportunity to discuss sleep-related issues from the night before.

2. Recognize that patients who experience significant guilt may be less amenable to treatment. Veterans with significant guilt associated with the traumatic incidents on which their dreams were based typically were more resistant to treatment. Veterans occasionally confused the representation of an event in a nightmare with the actual event, insisting, "It's reality, it's not a dream", or, "I can't change the past." An exploration of this resistance often revealed underlying guilt and the belief that the nightmare was a way to preserve and honor the memory of a dead buddy or important event, or to punish the guilty survivor. Some veterans have responded favorably to attempts to reframe such beliefs; in another case, a veteran eventually acknowledged and accepted that he did not want to change his disturbing target dream because, to him, it represented an acceptable means of memorializing a slain comrade.

3. Expect that reexperiencing dreams may not respond to treatment as readily as symbolic dreams. Dreams based on actual events, most often combat experiences, appeared more resistant to modification than did target dreams representing contemporary events, or those with symbolic or fantastic features. It was often helpful to acknowledge this in group but also to emphasize that factors maintaining a recurrent nightmare differ from actual historic events and are potentially subject to change even if the past is not.

4. Allow for and explore variety in content of alterations. People differed in their choices of alterations. Although some veterans were constrained by the belief that changes had to fit within the basic content of the dream, others were more imaginative and chose completely implausible scenarios. For example, one veteran had been flung into the air during an ammunition dump explosion, a terrifying experience which left him with a recurrent nightmare in which he consistently reexperienced that terror. In his alteration he became an airborne Superman, complete with cape, and flew out of Vietnam and back to America. Anecdotally, it appeared that veterans who incorporated more imagination into their alterations were more successful in decreasing recurrent nightmares.

5. Encourage individuals to specify a change wherever they feel it best fits. Previous research encouraged alterations at the end of the dream, but veterans often wanted to make changes in the beginning or the middle. We found that the nature of the change and where it occurred in the dream was not as important as simply selecting a change. It is possible that the rehearsal component of the treatment, with or without incorporation of a change, is an important aspect of this treatment.

6. Keep the groups small, and avoid conducting them at the end of the day or end of the week. As in trauma process group, discussions in the nightmare treatment group often triggered intense emotional reactions among veterans. It was important to allow sufficient group time to enable each individual to discuss any concomitant issues arising as a result of these triggered emotions. Therefore, groups consisted of no more than five veterans and were held during the middle of the treatment week to allow follow up.

The nightmare intervention group has been well received within the context of the program curriculum and often has been reported to be a group veterans valued most during their inpatient stay. Patients have described feeling as if they have been given a new, self-generated tool to apply to a highly refractory problem, leading to an increased sense of self-efficacy.

Anecdotally, it appeared that veterans who incorporated more imagination into their alterations were more successful in decreasing recurrent nightmares.

Efforts to evaluate treatment efficacy are currently under way, with one overall index of treatment success defined as zero occurrence of the target nightmare within a four week period following the intervention. By this criterion, approximately one-third of all patients treated thus far were successful. As in other studies, this measure of outcome effectiveness did not preclude the occurrence of non-target nightmares, which have sometimes been reported. Although outcome figures to date are low in comparison to published findings for imagery rehearsal interventions applied to primarily non-PTSD-related nightmare problems, findings appear to reflect a clinically significant outcome in this challenging sample, with multiple positive impacts within the EBTPU. Additional systematic exploration of such factors as implications of PTSD for nightmare treatment, comparison of symbolic versus trauma-based nightmares, and determination of essential components of treatment would improve our understanding of process and outcome in nightmare intervention.

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DEVELOPING A MODEL FOR CONTINUUM OF CARE

Michael Maxwell, M.S., C.T.S.

Treating patients diagnosed with Post-Traumatic Stress Disorder (PTSD) in a Veterans Affairs Medical Center is particularly challenging when you consider the aspect of continuum of care. Matching the patient's needs with the appropriate level and type of medical, psychological or social service can be difficult because PTSD services and programs are matrixed throughout the Medical Center and are often under different services and programmatic guidelines. In the Pacific Northwest, a continuum of care model has been in operation for the past several years, linking clinicians and other care or service procedures and programs across those formal institutional boundaries. A review of the history of the development of this model will point out both the rewards and the problems associated with developing a continuum of care approach to PTSD services.

The Pacific Northwest model for continuum of care saw its beginning with the opening of the Veterans Outreach Center in Portland in 1980. Vet Centers often saw themselves as outsiders to the VA System with the monumental task of providing comprehensive PTSD services to Vietnam veterans. When it opened, the Portland Vet Center was the only specialized PTSD treatment program in Oregon and Southwest Washington, with only three clinicians on staff. Rather than create an entrenched and isolated position, we felt it was essential to develop a network of providers within the local area and across the two states. Strong ties were established with Portland VA Medical Center clinicians who were willing and able to provide services complementary to those that the Vet Center offered. We realized that it was necessary to take a long range perspective on the problem and develop a vision for how services should evolve. Several informal sharing or exchange agreements were developed which capitalized on the unique and shared capabilities of the Vet Center and the Medical Center. For example, a Vet Center staff member joined the Director of the Outpatient Mental Health Clinic (OPC), Dr. David Drummond, to provide a PTSD treatment group at the OPC. At about the same time, the Vet Center Team Leader, Michael Maxwell, was joined at the Vet Center by a VA staff psychiatrist, Michael Reaves, M.D., to co-facilitate a Vet Center PTSD treatment group.

Beyond increasing the involvement of and communication between PTSD clinicians from different sites and disciplines, these initial liaisons led to collaborative planning and several innovative program developments. Dr. Drummond was instrumental in establishing a waiver policy that allowed clients from the Vet Center to be automatically eligible for psychiatric medication evaluation and monitoring at the OPC. Dr. Reeves joined the Vet Center as an administrative and clinical supervisor, initiating a psychiatric residency placement at the Vet Center, whose first graduate, Larry Schwartz, M.D., later became the team leader of the PCT and Director of PTSD services at the Portland VA Medical Center. When he subsequently moved to the positions of Administrative Officer for Psychiatry Services and the Assistant Chief of the Chemical Addiction Rehabilitation Section, Mr. Maxwell was able to further assist the coordination of PTSD services as a consultation and liaison service throughout the Medical Center and to develop a PTSD assessment and treatment track within the chemical dependency program.

As programmatic linkages were forged, a cadre of supportive clinicians also developed, and PTSD services expanded accordingly. Groups for couples, families, PTSD education, and for specialized populations (e.g., Korean and World War II veterans) developed along with growing capability to provide consistent individual and group PTSD treatment throughout the Medical Center and Vet Center programs. Also, various staff collaborated on PTSD research projects and publishing clinical articles, and the Vet Center became a training site for psychology interns and graduate students. In order to coordinate these rapidly developing PTSD services, a PTSD Coordinating Committee was formed. Originally comprised of clinicians from the Medical Center, OPC, and Vet Center, it came to include representatives from inpatient and outpatient psychiatry, psychology and social work services, a PCT, a PTSD Residential Rehabilitation Program (PRRP) and from the Vet Center in Salem, Oregon. The committee met informally as needed and formally on a monthly basis at each of the sites. It soon became apparent that an important role for the Committee was the staffing of difficult and chronic patients. During the first few meetings, discussion tended to gravitate toward the patients who were not able to thrive in therapy, and so a proactive attempt was initiated to identify and systematically develop and monitor collaborative plans for these veterans. Initially hesitant about taking time from their busy schedules, it took only a few meetings for those representatives to see the value of the Committee and to recognize how time spent at these meetings actually saved them time and improved the coordination of care.

To meet the goal of providing a continuum of care for PTSD treatment, the PTSD Coordinating Committee became involved in the development and expansion of PTSD services. One of the first priorities identified by the committee was a need for services for veterans with chronic PTSD who were homeless or unemployed. A proposal for a community based halfway house that would offer PTSD treatment and rehabilitation services was written by Dr. Roland Atkinson and Michael Maxwell, with the input and support of the coordinating committee. Although the proposal was not funded, it was used as the basis for a later proposal that was funded and became the PRRP. The PRRP now provides not only residential PTSD treatment but also a supportive community house component. Members of the PTSD coordinating committee also wrote the proposal for the PTSD Clinical Team (PCT) which was funded and has been in operation for the past 7 years. As the additional PTSD services grew, staff members of the new programs and services were

added to the coordinating committee. With the expansion of services, the coordinating committee also saw its role expand. The increase in programs and services increased demand for communication among the programs regarding admission procedures, services offered, eligibility criteria, and management of difficult patients.

Although not yet funded, proposals have been developed and submitted for a day treatment expansion of the PRRP, a community-based Psychiatric Residential Rehabilitation and Treatment Team for chronic PTSD, and a Women Veterans' Stress Disorder Treatment Team. As the PTSD coordinating committee was evolving in Portland, Drs. Ray Scurfield and Miles McFall were organizing PTSD providers in the state of Washington. They brought together PTSD staff from three VA Medical Centers, three Vet Centers, and the State of Washington Veterans Affairs Program. Their purpose was to extend the model for continuum of care for PTSD services across the state of Washington. Within a year of the inception of the Washington state committee, members of the Portland PTSD coordinating committee began to meet on a regular basis. In addition to focusing on coordination of care issues, the Washington state committee developed and implemented a unique PTSD program. Utilizing clinical and support staff from the State of Washington and the Seattle VA Medical Center, a PTSD Residential Rehabilitation Program was established in a state run Veterans' Home. The committee also assisted in the development of other PTSD services and programs such as: the outstationing of Vet Center staff at the American Lake Intensive Inpatient PTSD program; specialized services for Native Americans; outreach and treatment services for Desert Storm veterans; and the expansion of two additional Vet Centers in the state.

As the Oregon PTSD Coordinating Committee expanded to include representatives from Vet Centers in Grants Pass, Oregon and Eureka, California, and the Evaluation and Brief Treatment of PTSD Unit (EBTPU) at the Roseburg VA Medical Center, it was only a matter of time before the Oregon and Washington consortium linked up to begin working on coordination of care and collaborative planning for the Pacific Northwest area. In addition to developing regular lines of communication for patient referrals and aftercare, the combined Coordinating Committees have developed a genuine continuum of care for specialized PTSD treatment that features staged admissions and sequenced episodes of care across a system that includes two domiciliaries, three chemical dependency units, nine Vet Centers, two PCT's, a Substance Abuse Post-Traumatic Stress Disorder Team (SUPT), two EBTPUs, a Specialized Inpatient PTSD Unit (SIPU), two PRRPs, supportive community housing placements, and a state funded PTSD contracts program. Close coordination has also been established with veterans representatives from several state offices of Employment Development, Housing and Social Services, various local veterans groups and organizations, the Northwest Indian Veterans Association which represents over forty Northwest tribes, and with Service Officers from all over the state and national Veterans Organizations.

Recently, the combined Committees have developed a PTSD conference schedule for the Fall of 1995 that will be co-sponsored by VA Regional Medical Education Center and the State of Washington Department of Veterans Affairs. Spokespersons on PTSD services from the national, state, and local arenas will meet with several dozen VA Medical Center and Readjustment Counseling Service PTSD providers from the Pacific Northwest to share current developments and chart courses for the future. A task force has also been formed to explore the possibility of developing a specialized program to treat female veterans.

In sum, the development of a continuum of care model takes time, energy, resources, and an ongoing commitment, but the rewards are many as veterans benefit from the increased service delivery, quality services, coordinated care, a more educated staff, reduced patient and staff "splitting," innovative programs, a sense of team-work and camaraderie, and the system's capacity to match their needs with the appropriate level and type of medical health or social service.

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MENTAL HEALTH SERVICES AT THE COMPASSION CENTER: THE OKLAHOMA CITY BOMBING

Karen A. Sitterle, Ph.D.

Editor's note: Dr. Sitterle served as the American Red Cross Mental Health Services Coordinator at the Compassion Center following the bombing in Oklahoma City.

Karen S. Sitterle, Ph.D.

It was the most deadly terrorist bombing in American history. A massive truck bomb went off in front of a nine-story federal office building in Oklahoma City leaving 168 people dead— 18 of them children—and an additional 400 injured. In the hours following the blast, families of the three hundred thought to be missing, silently gathered at the First Christian Church searching for answers and information in a state of anguish and shock. As rescue workers attempted to formulate lists of those reported to have been in the federal building, family members faced grim requests for detailed descriptions, photographs, and medical/dental records of their missing relatives. Although chaos initially permeated the church, a multi-agency effort was quickly organized to provide accurate information about the rescue effort, to facilitate the efforts of the medical examiner's office, and provide emotional support. This site became the Compassion Center.

For the three week period until all 168 death notifications could be completed, the Compassion Center provided sanctuary for those keeping vigil and eventually provided the heartbreaking news when a body was recovered and positively identified. Day by day, families waited in hope. Unfortunately, all came to the same grim end: their loved one had not survived.

As a highly complex operation, the Compassion Center involved numerous emergency and community organizations working together to respond to the overwhelming physical and psychological trauma.

...every effort was made to empower families by providing information in a truthful, respectful and non-intrusive manner...family members were treated as normal people experiencing an abnormal event.

During the three weeks following the bombing, literally thousands of volunteer workers and hundreds of family members passed through the center. To facilitate the work of the medical examiner's office, the National Guard military, police, clergy, American Red Cross, Department of Veterans Affairs Oklahoma Medical Center, Department of Veterans Affairs Emergency Management Preparedness Office, and Salvation Army were able to integrate and work in a coordinated fashion to deliver immediate services. Mental health services were provided by mental health professional volunteers with the American Red Cross. Nearly 350 to 400 mental health professionals a day provided the multifaceted and anguishing task of providing support, solace and death notification to the families.

All mental health operations were guided by a number of principles (1). First, it was important to provide a sense of structure through leadership and communication at a time of overwhelming chaos and helplessness. Second, every effort was made to empower families by providing information in a truthful, respectful and non-intrusive manner. Third, family members were treated as normal people experiencing an abnormal event.

Not using stigmatizing mental health labels and providing nontraditional and practical services that emphasized active outreach and empowerment of the individual were key. In keeping with this notion, mental health professionals were labeled "escorts" rather than "therapist/counselor" (2). The third principle was to provide a safe and protective environment for families to share their pain with people who cared. Fourth, an understanding of the emotional climate and how it differed from an outsider watching on television was at the heart of the crisis intervention response at the Compassion Center. As optimism had waned outside the center and the rest of the country began slowly realizing that there was virtually no hope for more survivors, the family members continued to hold vigil under what appeared to be a blanket of denial against the realization of their worst fear. It seemed critical for families to remain hopeful, to be vigilant, to not abandon or betray their loved one until the death notification was made.

Mental health services were organized into four primary functions: support services, family services, death notification, and stress management services. Each mental health function was headed by a coordinator, who reported to an overall mental health supervisor. All coordinating staff had cellular phones to facilitate communication and quick decision-making.

Support Services

The convergence of volunteers, motivated but often untrained or unsuited to the job at hand, is a universal phenomenon in disasters (1). Thousands of individuals called or simply arrived at the Compassion Center to offer assistance, creating an overwhelming logistical problem for the center.

Support services were developed to devise a system to ensure that qualified professionals were selected, to prevent unauthorized persons from entering the center, and to handle many of the pragmatic aspects that arose.

This tragedy brought together volunteers who had never before worked together, had varying skill levels, and were unfamiliar with the procedures of the many organizations and agencies working at the Compassion Center. Mental health professionals were thus screened for ability and experience and then placed in a suitable position.

Given the stressful nature of providing death notifications, professionals with Ph.D.'s and M.D.'s or those with extensive counseling experience with death, grief and bereavement were selected to participate as members of the death notification teams. Individuals with debriefing experience, particularly training in Critical Incident Stress Debriefing (CISD) techniques, were recruited to staff the stress management/debriefing function. An attempt was also made to use mental health professionals from the Oklahoma City community and to place them in key coordinator positions. An extensive data base was also created where information about the professional's area(s) of specialty, address, hours available to volunteer, and phone numbers for accessing them were entered. A daily schedule was then created to provide coverage for all mental health functions for what was often an 18 hour day. Such coverage usually involved 200 to 350 mental health professionals a day.

In order to ensure that authorized persons were entering the center, a complex identification process was developed. All Compassion Center staff and family members wore identification with color-coded name tags. Each service or organization (e.g., clergy, mental health, medical, medical examiner, and media) was identified by a different color. Similarly, family members were designated with either a blue dot for next of kin or a yellow dot for extended or immediate family members. This identification system allowed both staff and families to easily locate each other when needed. To ensure privacy, the building was secured by the National Guard and the military. At no time was the media allowed into the building; however, a separate area was arranged for the media where regular briefings were made by the medical examiner and other staff at the center. In this way, families could meet with the media only if they chose, but it was done outside the center to protect the privacy of the rest of the families.

Family Services

Upon their arrival to the center, each family was given an escort (mental health professional) whose function was to provide an information link between the medical examiner's office and that family. Their job was to be aware of the families' whereabouts in case information was needed or became available. These escorts worked four hour shifts and up to two shifts per day. A two hour break between shifts was mandatory. Escorts were briefed prior to their shift as to current developments, problems, and available resources.

A family room was created to provide a meeting area for families to obtain information and support. Our goal was to create a safe, protective environment to meet the physical and emotional needs of the families and to provide protection from intrusions from the press and outside world. An attempt was made to keep families together in a single location where they could provide support to each other and be with other families that truly understood their situation. The emotional climate, particularly in the family room, was dominated by a mood of anguished waiting, emotional limbo, rapid change, and at times, conflicting information. Attempts were made to organize and structure the family room to be responsive to the ever changing needs of families.

It seemed critical for families to remain hopeful to be vigilant, to not abandon or betray their loved one until the death notification was made.

Cards and posters from school children's and individuals from all over the country wallpapered the room with loving support. Flowers sent from strangers decorated the tables set up as a gathering place for the families. Often a family would return to the same table, claiming it as their own and covering it with photos and mementos of their missing loved ones. Inside this huge room an area was set up to provide three daily hot meals for workers and family members. A constant supply of donated sandwiches, snacks, sodas, and baked goods were also available to families and staff. An area was established for families to make private phone calls using donated long distance service. Additionally, a cellular phone company donated hundreds of portable phones to families so they could be quickly reached if they left the center to go home or to work.

One corner of the room was set aside as a children's corner, filled with stuffed animals, colors, paints, toys, videotapes, and floor mats. This area was both separate but a visible part of the room, allowing children to venture into their own activities but still remain physically proximate to their caretakers. This area also allowed parents to take needed time away from their children to deal with their own feelings or to provide assistance to the medical examiners' office. The children's center was always staffed by a mental health professional with expertise in working with children.

As the days of waiting increased, activities were developed for the children to provide structure, distraction, and opportunities to be physically active. Animals were a part of these healing activities. Local mental health professionals with certified pet therapy animals, including rabbits, a sheltie, a Dalmatian, and an infant spider monkey staffed the room. Many of the children at the center were withdrawn or hyperactive and feeling as vulnerable as their parents. The opportunity to care for and play with pet therapy animals helped the children engage and focus as well as engendered a sense of control.

Another invaluable intervention for the families was the help of victim advocate, Victoria Cummock, whose husband was murderd in the 1988 terrorist bombing of Pan Am Flight 103. She met with families offering comfort, support, and her common experience. She visited homes, read stories to the children, and provided advice to both the mental health staff and rescue officials. *Editor's note: Ms. Cummock's observations are described in the previous issue of the Clinical Quarterly (3).*

Use of Briefings

A critical feature of family services was the establishment of an ongoing information link with the official rescue effort at the federal building. It was important to dispel rumors and provide accurate, official information. Regular briefings were conducted by the medical examiner's office two or three times a day to provide updates and to answer questions. Additionally, the government designated a state trooper to address any and all questions from the families. This uniformed representative met frequently with the families, to report up-to-date information about the rescue effort. A constant link to the rescue effort had a calming effect on the families and reassured them that every effort was being made to address their needs, to keep them informed, and to recover their missing loved ones.

Interaction Between Families and Rescue Workers

Another helpful intervention that evolved over time was the interaction between the families and the rescue workers at the federal building. Images of a ribbon held together by a guardian angel pin, a fireman hugging a family member, a child petting a search and rescue dog, and a fire chief searching the building site to find rubble for family members capture the special relationship that developed between families and rescue workers. The courage of the bereaved and the heroism of the rescuers bonded the two with mutual admiration and respect.

Clearly one of the most difficult tasks for families was not only having to wait but not being able to help directly with the rescue effort at the federal building. The bombing site was heavily secured by military and FBI, and only authorized personnel were allowed inside the perimeter. Families were therefore totally dependent upon the efforts of the rescue workers and reports from outside the center on the status of the search. To express their appreciation for the rescue workers, several of the families requested a machine to make ribbons for the firefighters and rescue workers. These families worked long hours fashioning thousands of ribbons held together by a gold guardian angel pin. The purpose of the ribbons was to recognize the valor and courage of the rescue workers and to provide guidance and support for them as the search continued. The firefighters were thankful and in fact, insisted on wearing the ribbons before entering the downtown site. One firefighter was known to become so upset when he was unable to find his pin that he tore apart his hotel room until he found it.

...a separate area was arranged for the media where regular briefings were made by the medical examiner and other staff at the center. In this way, families could meet with the media only if they chose, but it was done outside the center to protect the privacy of the families.

Several days into the search, families made a formal request to the mental health staff to have some of the firefighters meet personally with them at the center. When staff made arrangements for this visit, the firefighters expressed concerns that the families would be angry and disappointed with them for not having rescued any survivors. Much to their surprise, the families were deeply grateful and gave them a standing ovation when they entered the room. Family members waited to touch the rescue workers, to hug them, to talk with and put a face to those doing the search. This seemed to be healing for both the families and the firefighters.

This bond became particularly important when newspapers were delivered one morning with the large headline announcing, "All Hope is Gone: The Search is Over." The firefighters were reportedly discontinuing their search, and large machinery was going to be used to search through the rubble. This news spread like a shock wave through the family room. At this point, many families had still not been notified and became hysterical that the body of their missing loved one would never be recovered. To add to the turmoil, many families visualized the building site as a tomb, and the thought of remains being shoveled by machinery was very disturbing. To address these concerns, an emergency briefing was scheduled for families to meet with the governor, the fire chief, assistant fire chief, and the police commissioner to discuss how important decisions were made about the direction of the rescue effort. The officials were encouraged to share information in a straightforward, truthful fashion even though to do so was difficult.

This process culminated in a private ceremony and tour at the federal building for the families and recovery teams. Each individual scanned the building, often stooping, standing still, and staring. Mental health professionals, rescue workers, volunteers and chaplains lined the short route to provide privacy from onlookers, comfort and support. Police officers representing over twenty-seven departments, members of the military and fire department formed the honor guard. The Governor of Oklahoma and his wife also met with each family to offer their condolences. Families brought flowers, wreaths, balloons with messages, photos, stuffed animals, and crosses and rosaries to place at the building.

Death Notification Process

One of the most devastating moments that family members will remember is receiving notification of their loved one's death. In an attempt to make this horrific moment more tolerable, systematic death notification procedures using trained staff were established. Proper death notification can be one of the tools to assist surviving family members and speed the healing process. The notification staff was briefed on specific guidelines before participating in the notifications. For a list of death notification guidelines, please see Young (4).

The death notification process was clearly one of the most difficult jobs facing staff, particularly if it involved the loss of a child. The death notification team was headed up by two representatives from the medical examiner's office and included a mental health professional and a member of the clergy.

Once a body was recovered and positively identified by the medical examiner's office, the file was transferred to the center and protected by the National Guard. The family was then located and discreetly escorted

The death notification process was clearly one of the most difficult jobs facing staff, particularly if it involved the loss of a child. The death notification team was headed up by two representatives from the medical examiner's office and included a mental health professional and a member of the clergy.

to a quiet, private area in the church. The medical examiner's representative identified himself/herself and the next of kin before informing the family that their loved one had been positively identified as dead. After being notified, family members inevitably asked questions such as "Are you sure?" "How do you know?" And "Did they suffer?" The medical examiner responded by explaining how identifications were made and that the deceased had died immediately. Questions about the condition of the body and whether they could view the body were referred to funeral home representatives. The clergy member then offered a brief prayer to those families requesting one. Families were required to make a number of decisions about funeral home arrangements, when information could be released to the media, and whether other family members needed to be contacted. Finally, the team inquired if the family needed assistance or wished to be left alone.

Families responded to the news differently. Many seemed relieved that the wait was finally over, others were stunned, some became hysterical. Several family members returned later to the family room to help their new friends with what was to come.

Stress Management Services

The scope of human suffering at the Compassion Center was often unimaginable, creating a highly stressful and emotionally-charged environment. Given the unique stresses at the center, it was critical to provide stress management services for staff members as a separate function of the overall mental health operation.

Just like other emergency personnel, mental health professionals can be adversely affected by stresses. They are also normal people reacting to abnormal events. No one is prepared for the anguishing tasks and heartbreaking exposure to human suffering that was experienced during those weeks. This function was staffed by a coordinator and other mental health professionals experienced in disaster mental health and CISD techniques (5).

Defusings were one of the frequently employed techniques among the staff working at the center. Lasting 20-25 minutes, these sessions are short versions of the more formal debriefing process and are intended for a small group. All mental health and volunteer staff at the center were required to participate in a defusing after serving their shift each day. These defusings were held every hour so that staff could attend when convenient. Structured as a conversation about a particularly distressing event, the defusings contained three main components: introduction of the process, description of each person's role and their reactions, and suggestions to protect staff from further harmful effects. Pamphlets and handouts on stress reduction exercises, coping strategies, and stress management were also provided to staff. Members of the stress management team were also available to address staff difficulties on an individual basis.

Given the unique stresses at the center, it was critical to provide stress management services for staff members as a separate function of the overall mental health operation.

In closing, perhaps what was most remarkable in the aftermath of Oklahoma's sorrow was the courage of the bereaved and the heroism of the rescuers triumphing over this vicious act of terrorism. The overwhelming outpouring of compassion and support at the Compassion Center prevailed in the face of suffering and unspeakable sadness. While firefighters and search and rescue teams were hailed as heroes, the mental health volunteers who spent long, anguishing days at the center were also heroes. These were men and women from Oklahoma and around the country who put their personal and professional lives on hold to come to the aid of those in dire need. The common thread of all those who were present was their willingness to put themselves on the line for strangers and the belief that one person can make a difference.

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The work at the Compassion Center would not have been possible without the expertise and dedication of hundreds of mental health professsionals and volunteers. Special acknowledgements go to the following individuals for their unwavering commitment to the people of Oklahoma City: Tamara Vargas, M.S., Dana Foley, Ph.D., John Tassey, Ph.D., Ellie Lotterville, Ph.D., Barbara Cienfuegos, L.C.S.W., Dusty Bowencamp, R.N., and Cindy Besecker. The author wishes to thank Catherine Campbell for her comments and help in editing this paper.

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PERSONAL IMPRESSIONS OF THE FEDERAL BUILDING BOMBING IN OKLAHOMA CITY

John Tassey, Ph.D.

When discussing the events following the bombing of the Alfred P. Murrah Federal Building on April 19, 1995, in Oklahoma City, I am flooded with impressions, both visual and visceral, regarding my experience. It is my desire that the following will illuminate some of the personal challenges faced without being too idiosyncratic for more general appreciation.

In Oklahoma City, disaster mental health is a "niche" filled by only a few psychologists and social workers. By way of rotation and interest, on April 19th, I was the Chair of Disaster Mental Health at the Oklahoma County Red Cross Chapter, Co-Chair of the Oklahoma State Critical Incident Stress Management Team (OCISMT), and Coordinator of the American Psychological Association Disaster Response Network (APA DRN). A positive aspect of this disaster in our community is that more psychiatrists, psychologists and clinical social workers have expressed an interest in disaster and trauma training and so the delegation of responsibility should become more broad based.

Immediate and relatively unlimited access to the various disaster sites was assured by a pre-existing relationship with the command structure of the emergency response and law enforcement community. American Red Cross and Oklahoma State Critical Incident Stress Management Team (OCISMT) affiliations afforded me the authority to not only deploy mental health providers but also to petition for their use across a variety of settings. By responding to the smaller local and state "disasters" across the years, a good reputation has been established with the emergency services personnel, and our faces and procedures are familiar to them.

Arriving at the Federal Building about thirty minutes after the explosion, I was accompanied by four Catholic Social Ministries social workers. They were assigned in teams to the triage areas being established at the four corners of the Federal Building. They had no disaster or trauma response training or experience and wanted to know what "to do." Considering the number and nature of casualties, very little immediate crisis intervention was indicated. I also wanted "to do" something, so I assisted with carrying the wounded to triage areas. I do not believe it is disparaging to report that our presence within the first hour, on site, was a placebo effect. In fact, I think the value of an early mental health presence can not be overstated. A number of fire, EMS and Red Cross personnel mentioned how reassured they were to see me on-site, although they, as well as I, would have a hard time identifying what I "did."

The surviving unhurt children were first taken to the Red Cross Chapter two miles away. I received a call from the Family Services Coordinator that "mental health" was needed at the chapter for the children and the parents. With one telephone call (an important issue during a disaster when all lines and cells are overloaded), VAMC Psychology Service assured me that highly-qualified mental health professionals would be dispatched to the chapter. Across the afternoon and into the night these psychologists and psychiatrists were faced with the heart-wrenching task of consoling parents unable to find their children at the chapter or in area hospitals, and to others as they began to realize their loved ones were still in the building.

The incident command structure was established downtown within minutes of the blast due to the close proximity of the Federal Building to the police and fire headquarters. OCISMT members began establishing a presence at the rescuer, rest, and rehabilitation sites. Efforts to define one rehabilitation site for critical incident stress debriefing (CISD) were thwarted as the rest areas were moved eight times during the afternoon because of threats of another bomb, removal of potentially explosive ordinance, fear the building would collapse and the needs of preserving areas of the crime scene. Before dark, a site for CISD was permanently established in the incident command center and briefings and defusings began for every shift by order of the Oklahoma City Fire Chief.

The influence of the Oklahoma City Fire Chief's mandate for all personnel to be debriefed presented problems and advantages. The initial problem was recruiting peer counselors for CISD that *were not exposed* during the initial rescue efforts or ongoing search and retrieval activity. The value of our newly organized state-wide network was realized as out-of-town peer CISD counselors were recruited. An advantage of the mandate for debriefing was that other rescuers, not only OKC Fire Department, arrived at the end of their shift for debriefings. Within the first week, personnel from the Federal Emergency Management Agency (FEMA), local and federal law enforcement and most mutual aide fire departments were part of the debriefings. By the end of the initial operation, active duty and National Guard personnel were also "ordered" to report for debriefings before leaving their on-site posts. As the days turned into weeks, we were surprised to discover that many debriefing participants wished to address previous critical incidents as well — in some cases, these were events that had occurred on other assignments, but there were also instances when individuals brought up distressing military experiences.

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The intensity of the destruction, and the perceived motivation of the bombing, created a heightened security around the Federal Building/Incident Command perimeter and at all the major service sites. Security clearances were issued and revoked and volunteers, including some out-of-town mental health workers, were escorted out of the perimeter due to inadequate identification. But with the appropriate identification, nobody questioned why mental health providers were present or what they would be doing. Everyone understood and facilitated our activities and expressed appreciation at our presence.

The Medical Examiner declared that death notification would occur at one center and enlisted the use of one of the large local churches three miles from the Federal Building as closer suitable facilities had been damaged in the blast (see Sitterle article, this issue). The psychological impact of this center was appreciated by all at this facility, and the mental health coordinator early on was the facility coordinator, establishing the milieu to include both civilian and military security deployment, food services, training, screening, and family and staff policy. Since none of the psychiatrists or psychologists directing the death notification was over-rehearsed in any politically correct agency agenda, the needs of the family of missing and deceased loved ones was always the central mission. It would be impossible to describe all the subtle but significant changes that evolved over the three week course at the death notification center based on family member feedback, sensitive observation and a dedication to support the families.

Mental health providers were deployed at the Medical Examiner's office, the temporary morgue, and all the Red Cross service centers, shelters, disaster headquarters and chapter. In testament to how highly esteemed the VA psychologists were held by the Red Cross Mental Health Officer, by Friday, April 21, the manpower needs for immediate mental health services were met and all mental health volunteers were referred back to the community — except VA psychologists. Psychologists from the Oklahoma City VAMC were specifically assigned to areas requiring a depth of personal as well as professional experience, advanced organizational skills, and a respect for the confidentiality regarding material debriefed.

The civilian and military law enforcement personnel were a great asset to the overall operation but to mental health services in particular. Their presence, literally surrounding the building at the death notification center, was reassuring to the family members, staff and volunteers. They were compassionate, respectful and ever-faithful in their protection of the family members, and enthusiastically unrelenting in their isolation of the media from the family members. We modestly returned the favor by defusing/debriefing their sentries, often in traditional CISD fashion but sometimes in "Hummers" at isolated checkpoints in the early morning hours.

The media was ever-present and resourceful (cunning) during the first four weeks after the bombing. The local affiliate stations were considerate of the operation and some of the news crews first on the scene abandoned their equipment to assist with the rescue effort. The national media arrived before the first FEMA team and was most interested in exposing the gore, grief and conflict of the disaster. The international media seemed only interested in sending back something that identified that they were in Oklahoma City. Public affairs officers from local, state and federal services and agencies postured to exploit the extensive media coverage available. Since I find talking with the media a valuable public service for someone else to provide, I developed two strategies to avoid interviews. The first was to isolate myself in secure areas where media were not allowed. My backup method was to provide a boring, obviously over-rehearsed statement which was counter to the sensationalism the media was seeking. Working to my advantage in the avoidance of the media was the knowledge that they do not have the luxury of waiting for me and that their deadlines necessitate finding someone else.

I encourage those that enjoy talking with the media to consider how their media exposure influences the relationship with the populations they will be interacting with during the disaster response. My experience is that most rank and file law enforcement and firefighters as well as many disaster victims view the media as "the enemy," or at least with much suspicion regarding their motivation and sensitivity. A high profile media relationship would contaminate relationships and diminish access, both physically and psychologically. My observation is that during a disaster, first impressions are highly weighted and often an opportunity to exonerate oneself does not present itself.

During the immediate and acute phases of a disaster, we found that critical incident debriefing offers emergency personnel a vital opportunity to begin the long process of adjusting to the trauma encountered. It was also clear that emergency workers benefit from multiple debriefings and that the debriefing process should, in effect, continue for several months after deployment. More specifically, conducting post-deployment debriefings has several benefits: 1) workers are able to understand and correlate their response to normal stress syndromes, thereby giving them the opportunity to normalize and universalize their reactions; 2) by holding debriefings after a period of time, any psychic numbing that may have occurred in workers may have diminished, thereby giving workers greater flexibility to discuss emotionally-laden experience; 3) post-deployment debriefings can serve to identify and refer workers who may need individual help.

Debriefing is not psychotherapy. Regrettably, I received feedback from many law enforcement and fire service personnel about well meaning mental health providers trying to "get in my head." These are legitimate complaints by emergency personnel who see themselves as competent, having to do a difficult job, and are concerned about being labeled with a diagnosis. Though a debriefing may be obligatory, workers are not seeking, nor necessarily in need of, treatment. Rather they benefit from the opportunity for catharsis, to verbalize trauma, from group and peer support, and from information about common stress responses.

This experience has taught me a good deal about myself, various relationships and the resilience/ fragility of our human existence — and politics. I have learned to respect people I previously could not tolerate. I am humbled by the outpouring of support. I hope this article can be a conduit to express my profound appreciation and the thanks of our community for the genuine and generous contributions extended to us during this disaster.

John Tassey is Director of the Behavioral Medicine Clinic, Department of Veterans Affairs Oklahoma Medical Center and Assistant Professor, Department of Psychiatry and Behavior, Oklahoma University Health Science Center.

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CLINICAL TRAINING PROGRAM POST TRAUMATIC STRESS DISORDER

The Clinical Laboratory and Education Division for the National Center for Post Traumatic Stress Disorder at the VA Palo Alto Health Care System, in collaboration with the Long Beach CA Regional Medical Education Center (RMEC) offers an on-site clinical training program in the treatment of Post Traumatic Stress. The training program is approved for category 1 continuing medical education credit.

Psychiatrists, psychologists, social workers, nurses, readjustment counselors, clinical nurse specialists, occupational and recreational therapists combine to provide a comprehensive treatment program and an education experience for the mental health professional seeking to expand his or her understanding of psychic trauma and its treatment. The Clinical Training Program offers a broad range of educational activities including:

* Lectures
* Clinical research observation
* Supervised clinical activities
* Use of multimedia materials
* Group discussions facilitated by staff

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, generally on the third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or RMEC. For further information, please call FTS 700-463-2673 or commercial number 415-493-5000, extension 22673.

Our apologies...

the brief "bios" of authors Jeffrey Brandsma and Lee Hyer "Resolution of traumatic grief in combat veterans," (Vol 5. 2-3) were not included in the issue. Both are clinical psychologists and Professors of Psychiatry and Health Behavior at the Medical College of Georgia. Dr. Hyer is also a clinical psychologist at the Augusta VAMC.